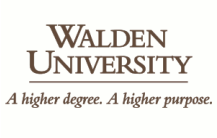

2018

Addressing Spiritual Care Needs in Primary Care

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This is to certify that the doctoral study by

Olayinka Akerele

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
2018

Abstract

Addressing Spiritual Care Needs in Primary Care

by

Olayinka Akerele

MS, University of Maryland, 2011

BS, Towson University, 2004

Project Submitted in Partial Fulfillment

Of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

May 2018

Abstract

This DNP project focused on the spiritual aspects of care that are often neglected in the outpatient setting. Most patients value their spiritual health and believe that it is just as important as their mental and physical health. The purpose of this project was to improve the overall spiritual care provided to patients, their families, and/or caregivers in times when they were experiencing spiritual distress. This quality improvement (QI) project was designed to determine whether embedding a chaplain in an outpatient clinic instead of providing a pamphlet about chaplain services increases patient satisfaction. Secondary analysis of the data in this project show that of 306 patients who completed the 4-item screener, 70 patients were identified as having spiritual distress. There were 34 people who benefited from having an embedded chaplain. Spiritual distress was measured using a 10-item survey prior to and after seeing the chaplain; a 3.7 point decrease was seen across 6 patients. It was not a statistically significant improvement, largely due to the small sample (p=.08). Non-parametric chi square fisher exact results showed that satisfaction scores were higher in 5 patients seen by the chaplain (p=. 048) versus 4 not seen by the chaplain. Qualitative results were obtained from 5 chaplain participants were all positive. Though a very small sample, this QI project emphasizes that spiritual care needs are an integral part of holistic care provided through nursing practice. Nursing is tasked to be concerned with each person's human experience, which includes spirituality. This QI projects' contribution to positive social change is that it enhanced the health outcomes and quality of life of those participants involved.

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Dedication

I dedicate this paper to my wonderful family. They have been my rock and sounding board during this DNP program period of time in my life. They give me the strength and inspiration I need to continue on this difficult journey. I am forever grateful and in gratitude for their support, prayers, and words of encouragement.

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I will like to acknowledge my committee chair Dr. Barbara Niedz who has been instrumental in my development of this project proposal with all her support and advice along the way. I will also like to thank my husband, Dr. Oyetola Olufidipe who has been my rock and support through the years of this vigorous DNP program; he unfailingly speaks words of encouragement to me when I most need it. Finally, I will like to thank my family and friends who have also supported me through this journey and filled in for me whenever they could at work and special events.

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Section 1: Addressing Spiritual Care Needs in Primary Care

Introduction

Spiritual care is provided by helping patients cope with stressful situations, improving patients' treatment satisfaction, and by giving patients an opportunity to express their personal spirituality (McClung, Grossoehme, & Jacobson, 2006). Spirituality is seen as a broad term to describe a sense of purpose in life and connection to something greater than oneself. Religion, on the other hand, is a set of communally held beliefs that are publicly expressed. According to Borneman, Ferrell, & Puchalski (2010), spiritual or existential distress presents itself with physical symptoms such as pain, agitation and depression or anxiety.

In health care, nurses have prided themselves in providing holistic care, which encompasses patients' physical, psychological, and spiritual needs. However, chaplains have not been used in the outpatient venue as much as they might to provide a key assist in identifying and meeting patients' spiritual needs (Gomez-Castillo et al, 2015). It is therefore imperative that chaplains become visible and available in the outpatient setting to engage in discussions and to serve as a resource addressing the spirituality needs of patients and families. As much as nurses have the educational training to provide spiritual care to their patients, Burkhart and Hogan (2008) found that two-thirds of the nurses in the study did not believe that they provided adequate spiritual care to their patients. Two of the major barriers noted by the nurses in the study were that they lacked the education and the time to adequately provide spiritual care to their patients.

This DNP project focuses on the spiritual aspects of care that are often overlooked and neglected in the health care arena. Most patients value and believe that their spiritual health is just as important as their mental and physical health. (Glombicki & Jeuland, 2014). The nature of this project was to explore further the reasons why spirituality is often ignored, overlooked, and neglected in most health care settings, and to provide solutions to address this problem through a screening process, an educational plan for staff members, and a newly developed role with a referral process in the primary care setting. In today's society, the social implications of this positive change will help not only patients' satisfaction with the care they receive in the health care setting but also their recommendations to their families and friends.

Problem Statement

At the study site, the nurses, providers, and ancillary staff are focused on the flow of patients, and on the urgency of their acute needs. Staff members are focused on patients' physical and mental health needs; however, any attention to spiritual needs is variable, not standardized, and not a part of the staff member's current frame of reference. At the inpatient acute care facility that is associated with the study site, there are two questions asked about the patients religious and spiritual background and needs while hospitalized; however, in the outpatient setting there is no such screening conducted. On the clinic intake form, there are health related questions that are asked of the patient, but none of these questions relate to the patient's spiritual needs. That becomes a missed opportunity that health care providers could use to screen and identify patients needing spiritual counseling or support.

One of the providers in this clinic often saw patients whose spiritual struggle was reflected in their mannerisms and responses. This provider would often walk the patients down to the chaplains' office for further assessment and consultation. However, for as often as this single provider would provide this service, there were many other providers who were blinded to this type of intervention because they have not considered the patient's spiritual needs. This example shows that there are patients who could be easily identified through conversations about their spiritual and religious needs and who could benefit from some spiritual counseling. According to Rogers and Wattis (2015), considering and contributing to something that gives patients hope, meaning, and purpose in life are the essence of properly addressing the spiritual needs of the patient.

This doctoral project has significance in the field of nursing practice because according to the International Council of Nurses and Nursing and Midwifery Council, when spirituality is integrated into nursing care it indicates good practice standards of the discipline, and not doing so is detrimental to providing high quality care (Rogers & Wattis, 2015). Sperry (2016) stated that when spiritual care is needed, many health care providers are hesitant to address it and often unsure of what to do. The purpose of this project was to ensure that providers (nurses and doctors) are more comfortable embracing the spiritual needs of their patients and can help them if spiritual struggle or distress is noted.

Purpose of the Project

The purpose of this project was to improve the overall spiritual care provided to patients, their families, and/or caregivers in times when they are experiencing spiritual

distress or are morally injured. There are spiritual resources that many providers in the clinic do not use or are not aware of.

The gap in practice that this doctoral project addresses is that nurses and providers at the study site do not have the skills or tools to address the spiritual needs of their patients. A prominent way to address that gap is to provide appropriate education to nurses and providers. In fact, current practice is that if a patient is suspected as being in distress or experiencing struggle, they were given a brochure about the spiritual care department and told to reach out to them for assistance. This practice does not indicate that adequate care is taken or available to providers to offer the best well-rounded care of their patient population. This haphazard practice could lead to compromise of the patient whose spiritual distress is not addressed. Often illness, a difficult diagnosis, loss of a loved one, or surgery could lead patients to either question their faith or lose hope and meaning in life. That is the best time to identify and intervene on behalf of someone who requires assistance.

A prominent way to address this gap in practice is to provide appropriate education for nurses and providers to enable them to confidently talk to patients about spiritual concerns and be more aware of different spiritual and religious practices in order to provide culturally competent care (Nelson, 2016). The lack of education regarding spiritual care as part of caring for the patient holistically stems from a disconnect in applying theory to practice in clinical settings. For example, patients often present to health care settings with somatic complaints that lead to providers ordering blood tests to determine the physical cause. The gap in practice is that providers keep looking in the

same place and repeating lab tests for patients who may be suffering from spiritual issues that manifest as physical symptoms with no medical origin (Khalifa & Khalid, 2014).

There is also a gap in collaborating with key community faith-based practitioners who could assist patients in their local communities (Parrish, Kinderman & Rabow, 2015). From a nursing perspective, providers often look to other disciplines to provide certain medical care for their patients, but when it appears to be spiritually based, there seems to be no resource available for the patient. As a health care discipline, nurses have not fully developed collaboration processes for the spiritual domain; the likely option remains initiating the process of referral to the chaplain. Hospital-based providers do not often reach out to their community counterparts such as community faith-based nurses or parish nurses (Rosenbloom, 2005).

Project Question

The central question for this project study was:

PQ: Will embedding a chaplain in an outpatient clinic (new practice) instead of providing a pamphlet about chaplain services (standard practice) increase patient satisfaction among the study site population?

Project Potential to Address the Gap

My intent for this DNP project was to engage patients and caregivers to be transparent when spiritually-based questions are asked in order to appropriately determine if patients are currently in spiritual distress. Staff would have the ability to determine if a particular patient is spiritually disturbed based on mannerisms and answers

to certain targeted questions that would be included in the assessment portion of the clinic visit.

The health care team needs to be competent enough to meet the basic spiritual care needs of the patient such as support during times of prayer, meditation, or with certain religious dietary restrictions (McClung et al., 2006). The main objective of this project was to help patients through any basic, intermediate, or advanced stressful situation by providing support at all stages of need via a chaplain. Staff members have the ability to complete an assessment, place a referral, and offer spiritual support as much as it is needed to ensure patient satisfaction goals are met during their time in the health care facility.

An objective of this quality improvement (QI) project was to engage the entire health care team to better understand what it entails to provide holistic care that taps into the spiritual needs of the patients who are seen. Education of the staff will be beneficial to the organization, the individual, and their patients because the patient would be the beneficiary of all knowledge that the staff holds. In addition, chaplains need to broaden their scope by attending interdisciplinary meetings with staff members to enable discussions surrounding how to build awareness of spiritual needs. A final objective was that chaplains and staff would work collectively to assess and treat patients who meet the requirements and be able to provide the spiritual care required. This will help the organization improve the patient's experience as measured by the patient satisfaction survey and increase patient referrals to the chaplain. This objective was measured by having patients rate the level of care they receive from the chaplain and staff of the study

site. The objectives were measured at each phase through an evaluation tool that helped ensure the team meet each deliverable. It was prudent to evaluate at each phase of the project rather than at the very end.

Nature of the Doctoral Project

The DNP project provided spiritual care, counseling, and support to patients who self-refer or are referred to the embedded study site chaplain in a primary care setting. In this QI project, patients were screened, referred for spiritual care, and then engaged in one or several visits with a study site chaplain. The DNP QI Project was characterized by the following components: (a) a four-item screening tool and ten-item spiritual assessment tool incorporated into outpatient intake, (b) referral to the outpatient chaplain in real time, and (c) an educational program provided to outpatient study site nurses with information about assessing and meeting spiritual needs of patients. The strategy was part of an overarching QI initiative supported by the mission of the organization and identified for 2017 as a QI priority.

The source of evidence that was collected to meet the purpose of this doctoral project was from the screening tool completed by patients before and after the spiritual care referral was initiated. This tool was partially derived from the spiritual distress survey of the National Comprehensive Cancer Network (2017) and had been in use in other hospitals in the project site system for over 5 years. There were patients who screened positive for spiritual distress using a four-question screener tool on intake and were triggered to have a pastoral care consult based on their responses. The screening tool would highlight the knowledge of the individual before the interventions with the

chaplain by asking questions related to their current thought processes, any struggles they were having coping with their medical conditions, and their spiritual state of mind. King, Jarvis, and Schlosser-Hall (2006) have shown that in the outpatient setting, patients who have no familial or social support are often those who struggle spiritually.

The patient satisfaction survey gathered information from participants about their level of satisfaction with the care provided after meeting with the chaplain. This QI project leveraged the already existing patient satisfaction survey that was completed by all patients during the course of their care at the study site. Results of the survey were made available to the project team after it was tabulated by the facility. The results of the patient satisfaction survey were used to evaluate the progress of the project. The linkage between the overall patient satisfaction and meeting the spiritual care needs of the patient is that both were accomplished by the QI project. The patient satisfaction survey was a total of five questions with four forced-choice Likert scale options to obtain results from all participants of the spiritual care program. The chaplain administered the survey at the last visit with the patient. The preintervention survey results were marked as such and the postresults were marked accordingly. The survey was used to evaluate the effectiveness of the newly implemented program as results were obtained throughout the course of the project. Pre- and postintervention results were reviewed monthly to identify trends in respondents' responses.

As part of this QI initiative, the chaplain gathered the responses from the surveys at the end of the last scheduled visit, and responses were analyzed statistically. The approach that was used is that surveys were labeled pre and post for analytical purposes,

but respondents' information and identities were completely confidential; for the purpose of data collection in this project respondents were anonymous. To analyze pre- and postsurvey responses, *t* tests were used. Basic demographic information such as age, sex, and medical conditions were not obtained and used for analytical purposes. The QI approach was that patients who screened positive for spiritual distress using the four-item screening tool on intake were referred and encouraged to meet with the embedded study site chaplain. Therefore, all patients who screened positive or self-referred were warmly handed off to the chaplain embedded in the study site and a consult for pastoral services was entered in their charts.

The chaplain at the study site was responsible for most of the data collection in this QI project designed to increase referrals to the chaplaincy program. Data collection included recording the transactions completed at the patient level to ensure tracking of (a) patients to whom brochures were given, (b) patients with pastoral care consults, and (c) patients who were warmly handed off to a chaplain in the moment for further interventions. As a result of this project, I expected to determine if this referral process increased the number of patients who were adequately identified and treated for spiritual distress or provided spiritual care in the clinic setting. The findings from this project confirmed that the current gaps in practice that were detrimental to patients' spiritual health were closed.

Significance

The stakeholders for this project were the leadership team of the study site, the interested providers, and the collaborators from the overarching inpatient facility who

wanted this project to be a success. The team had a key interest in this population of patients because they are either active duty servicemen or veterans of the country who have been through one or more deployments to war-zone areas. These patients are often suffering from posttraumatic stress disorder, loss of limb, or near-death experiences that have the potential to cause spiritual distress symptoms. Addressing this problem is a significant QI priority for the stakeholders of the project, and they were well vested in the process and planning of the project as it has been included in the strategic plan for QI.

Spirituality is relevant to health care today because it encompasses a part of an individual that affects the whole person. Spirituality affects mental health and coping and is a positive resource for adaptation in all individuals but especially in the military population (Foy, Drescher, & Smith, 2013). King et al. (2005) have shown that staff members who receive spiritual care themselves provide better care to their patients with the involvement of chaplains. Furthermore, spiritual and religious practices have been shown to positively affect coping and overall medical outcomes, adding to the significance of this project (Piderman et al., 2008). Hospitalized patients are increasingly considering spirituality as an important part of their hospital experience (Piderman et al., 2008; King et al., 2005).

Professional standards of nursing practice expect those in the discipline to pay close and special attention to the spiritual care needs of their patients. This is emphasized in formal nursing education and reflected through the NCLEX examinations. The importance of a spiritual care curriculum and stressing the importance of not only assessing but also meeting the spiritual care needs of patients is part of nursing education.

Meeting the spiritual care needs of patients does not have to be the sole responsibility of a person in one discipline but can also be an objective of the multidisciplinary team in addition to using the chaplain (Glombicki & Jeuland, 2014).

This doctoral project helped educate the nursing staff at the study site that they can contribute to not only the physical care of their patients but also their spiritual needs. Nursing staff become more empowered to identify and help treat patients struggling with spiritual distress, which can improve the patient's overall outlook regarding the care provided to them. This project could help improve practice in other clinics outside of the study site, such as the women's health clinic, that often deal with spiritual concern issues (Gomez-Castillo et al., 2015).

People undergoing spiritual distress often have feelings of despair, fear, bitterness, and anger towards God, which is often difficult for clinicians other than chaplains to deal with (Cary & Rumbold, 2015). Chaplains are tasked with helping patients finding meaning in life through the chaplains' knowledge of theology (Graham, Brush, & Andrew, 2003). As patients undergo spiritual struggles and despair, it is crucial that hospitals meet the Joint Commission on Accreditation of Healthcare Organizations mandate to complete a spiritual assessment on every patient (Marin et al., 2015) The purpose of this assessment is to discern if any religious, spiritual, or other belief systems are present that might impact the patients' hospitalization (Marin et al., 2015).

The implications of this project for the larger body of health care can be substantiated based on the overall results of satisfaction scores. If successful, this project could likely be transferred to the women's health care clinic or the pain clinic for their

patient population as well. Patients might benefit from additional referrals that could be to hospice or mental health if applicable for their situation. Other small or large teaching hospitals could use this new practice of embedded chaplains in their own outpatient clinics as well. Physician group practices could use this model to help them quickly identify patients who need referrals to spiritual care and other such referrals.

Implications for Social Change in Practice.

Social change can be potentially achieved in that spiritual screening would be incorporated into the history obtaining process for all patients. If a validated tool is used to screen all patients for spiritual distress, then caregivers will have lower levels of incidences of injury to self and others. Society will be positively impacted because service members and their families would find support for their spiritual struggles and would feel less reluctant to open up to their providers. As a society, persons struggling with spiritual issues that are unresolved or ongoing may commit most crimes or self-injure (Foy et al., 2013). Chaplains should be considered as vital members of the health care multidisciplinary team in almost all health care settings.

Summary

Spiritual Care is often overlooked in the health care setting. There is a great opportunity to provide holistic care in any health care setting, but often this option is neglected due to lack of training/education, time, resources, and staff. This is a society where moral injury, spiritual distress, and lack of resiliency are at a peak (Foy et al., 2013). The use of chaplains to provide the highest level of spiritual care possible is

recommended for all health care settings. In the next section, I delve deeper into the concepts, model, and theories and the topics relevant to nursing practice.

Section 2: Background and Context

Introduction

The practice problem was that spiritual care is minimal or nonexistent in the primary care setting in most health care facilities. The question this project answered was: Will embedding a chaplain in an outpatient clinic (new practice) instead of providing a pamphlet about chaplain services (standard practice) increase patient satisfaction, among the study site population?

The purpose of this doctoral project was to conduct a QI pilot project in the study site. We conducted the project with this particular population in the study site because of the amount of support we received from the leadership team and staff members who were willing to improve the type of care provided to their patients. The staff were able to realize that changes were warranted to improve the care provided to their patients by using chaplain interventions. In order to help solve this problem, it was imperative that changes in the staffing of health care personnel included chaplains, who were needed in the primary care setting. Resolving this issue would help health care providers and facilities as they work to provide the best overall, well-rounded care possible to their patients. This can be accomplished by referring patients, when needed, to the chaplain in the study site for support and counseling as required. In the next few paragraphs, I discuss concepts, models, and theories that help illustrate this topic.

In the health care field, spiritual health is emerging as a new field that is gaining increased attention in the literature. The definition and role of spiritual care were paramount in this QI project (Puchalski, 2013). Research has shown that spirituality plays

a significant role in a person's health, quality of life, and overall well-being (Marin et al. 2015, Puchalski et al., 2006; Winter-Pfändler & Flannelly, 2013). Spirituality plays an ever-greater role in the health care system; evidence-based medicine and technical attention is moving from focusing solely on the physical aspect of care to a more holistic approach (Marin et al., 2015).

Concepts, Models, and Theories.

The biopyschosocial and spiritual model of care is also known as "whole-person care," which includes a spiritual dimension pervading the physical, the social, and the psychological realms (Puchalski, 2013). The patient-centered medical home approach provides a better-coordinated team-based care that improves outcomes and lowers costs (Russell, 2014). Having a nurse case manager in addition to an electronic medical record are the requirements for having a patient-centered medical home (Russell, 2014). In a patient-centered model, the patients' primary care physician not only provides primary care but also coordinates the medical team with other providers (Fitchett, Nieuwsma, Bates, Rhodes, and Meador, 2014).

There are various factors with the health care team that prevent accurate and timely assessment of patients' spiritual needs. In nursing, some barriers have been lack of appropriate training and education with limited resources provided to the discipline. Also, nurses have been conditioned to not ask their patients about their religious beliefs or talk to patients about this sensitive topic, which is often confused with spirituality. Recently, nursing literature has distinguished spiritual care as a broader concept than religion, thus

sparking conversations between patients and nurses on topics of spirituality (Puchalski et al., 2006).

Spiritual Care

The linkage between spirituality and health care has prompted research interest in medical literature the mid-1990s (Russell 2014). In an article by Foy et al. (2013), the authors focused on the positive effects of spirituality in the lives of active duty servicemen in the United States. They found that many marines stated that their faith provided them with a sense of meaning in life and having a special place in the world (Foy et al., 2013). Prayer was reported as the most commonly mentioned source of spiritual support that helped during times of need, fear, or desperation (Foy et al., 2013).

Spiritual care requires an assessment of that aspect of a person's wellbeing. The nursing profession requires assessment and nursing diagnosis of spirituality-related issues, therefore necessitating interventions to help resolve them. Spirituality is an individual, subjective way of finding meaning in life that relates specifically to a person's beliefs and values (Caldeira et al., 2014).

Nieuwsma and Rhodes (2013) conducted a study with full-time Veterans Administration (VA) and active duty Department of Defense (DoD) chaplains using a web-based survey to determine their attitudes and knowledge about mental health issues, how they collaborated with mental health providers, and their overall practices as they related to spiritual and mental health care. Task force members from the VA, the DoD, and nonmilitary organizations developed the anonymous survey. The sample size consisted of 2,163 chaplains in both sectors responding at a rate of 75% for VA and 60%

from DoD (Nieuwsma et al., 2013). In addition to the quantitative data from the surveys, the authors also conducted site visits to help establish some qualitative data in the study. The study was intended to generate opportunities for creating an integrated chaplain care–mental health teams, and identify gaps in knowledge, structure, or practice relating to mental health and chaplaincy teams (Nieuwsma et al., 2013). Interviews were conducted at both VA and DoD facilities and a joint VA/DoD facility using a grounded theory method to code interviews and identify themes (Nieuwsma et al., 2013).

The findings of this study showed that VA and DoD chaplains were similar but had some distinct differences. For example, VA chaplains worked primarily in the inpatient areas whereas DoD chaplains worked mostly in nonclinical areas. The survey produced the distinction that VA chaplains were in fact veterans themselves who tended to be older, highly trained, proselytizing or attempting conversion to an alternate faith. The survey results revealed that VA and DoD chaplains commonly worked in inpatient areas with general medicine providers and saw more mental health cases with the veterans and service members they frequently visited. Stigma, availability of a chaplain, and confidentiality were all qualitative reasons why chaplains were requested, despite available mental health services (Nieuwsma et al., 2014).

Barriers and Strategies to Enhancing Spiritual Care

There are several barriers to enhancing spiritual care in the health care setting. There are certain knowledge, attitudes, and behaviors that are considered detrimental to providing good spiritual care to patients and families. These attitudes and behaviors are manifested in a lack of education of health care providers to help them offer the best

possible interventions for patients in need. Russell (2014) explained that many physicians feel unskilled and unprepared to identify and discuss spiritual concerns with patients, which results in the lack of holistic care.

Nieuwsma et al., (2013) noted barriers to achieving better integration of chaplaincy and mental health as a lack of bidirectional referrals to each other and the lack of forming collaborative relationships between both groups. Mental health professionals and chaplains alike face struggles with building trust and confidence in each other due to lack of familiarity, which leads to limited integration among the disciplines (Nieuwsma et al., 2013). In the survey conducted, VA and DoD admitted to understanding the role and value of mental health; however, 56% of chaplains in the VA and 46% of DoD chaplains felt their work was well understood by mental health professionals (Nieuwsma et al., 2013). One of the solutions proposed by Nieuwsma et al., (2013) was to conduct integrated training for both chaplains and mental health professionals to improve communication between the disciplines and ensure there are opportunities for interaction between them to create continuity of care for servicemen and veterans.

In another study by Fitchett et al. (2014), the authors conducted a survey of VA, DoD, and a comparable sample of civilian chaplains designed to enhance the mental health needs of servicemen and veterans. A web-based survey was conducted to assess knowledge and practices regarding mental health issues of 440 VA chaplains and 1,723 DoD chaplains (Fitchett et al., 2014). The overall basis of the study was to obtain results about the evidence-based care and instruments used in chaplain care, especially among the civilian chaplains. Among the chaplains surveyed, Fitchett et al., found that most

were extensively trained and certified in their profession. A barrier that was noted in this study by Fitchett et al., was that chaplains were not actively involved in research teams; in spite of this, an outstanding three-fourths of VA and DoD chaplains considered their care evidence-based.

A strategy that has been utilized by the Salvation Army chaplaincy program is found in their recruitment efforts to hire chaplains with certain desirable skills, knowledge, and practices considered necessary for competent chaplaincy (Carey & Rumbold, 2015). Some recommendations for advancing knowledge about spirituality and military service is that providers need to be better prepared and knowledgeable about the complex interface between spirituality and combat related issues and trauma (Foy et al., 2013). Another approach that has gained popularity is the interdisciplinary team-based approach to holistic health care with the use of chaplains for evaluation and improvement of pastoral care (Crane, 2000). Chaplains serve in these interdisciplinary teams as spiritual support providers, engaging with the patient's faith community as appropriate, and contributing information to the team on ethical and spiritual matters pertaining to patient care (Russell, 2014).

In a cross sectional analytical study by Ebrahimi et al. (2017), 555 nurses from a hospital in Iran participated in the research. The focus of this study was on the nursing profession due to the expectation that nurses should provide holistic care to their patients. The idea presented was that the core of each patient is spiritual, with that influencing the biological, psychological, and social realms of that individual. Competence is a set of personality traits and characteristics that relate to the skill, knowledge, culture, education,

and attitude of the nurse, which guarantees the quality of care provided to their patient. Other studies have shown that there is a correlation between the level of a nurses' internal spirituality and how they will provide spiritual care to their patient. It is crucial to note the importance of nurses understanding their own abilities and perceptions of spirituality in order to adequately assess spirituality needs with a patient (Ebrahimi et al., 2017).

Ebrahimi et al. (2017) used demographic and 27 likert scale spiritual care competence questions that were asked of the respondents. These questions were about individual support and patient consultation, communication, professionalism, improving quality of spiritual care, evaluation and implementation of spiritual care, expert referrals, and attitude towards religion. The minimum expected score is 27 and the maximum of 135 and any responses below 64 is equivalent to having low spiritual competence, 64-98 is average spiritual care, and above 98 indicates high spiritual competence (Ebrahimi et al., 2017). Ebrahimi et al. (2017) found that the perception of nurses providing spiritual care fell within the average scores. In this cross-sectional study the nurses scored average as reflected by the competence level 95.2 ± 14.5, which correlates with another similar study by Sabsevari, Bonashi, and Borhani in 2013 that resulted in a competence level of 97.5 ± 13.6 (Ebrahimi et al., 2017). These results are indicative of a need to better promote spiritual care by nurses since most nurses primarily focus on physical care of their patients. Training of nurses in activities such as workshops would be beneficial for leadership to promote and increase nurses' spiritual care competency (Ebrahimi et al., 2017).

Spiritual Screening and Assessment

The spiritual care screener tool that was used by patient care techs, nurses, and providers to screen patients for spiritual needs is the Spiritual Care Survey. This tool was partially derived from the spiritual distress survey from the National Comprehensive Cancer Network (2017). There are patients who screen positive for spiritual distress using a four-question screener tool on intake, who were triggered to have a pastoral care consult based on their responses. The embedded chaplain, provider, and nursing staff provided all patients that present to the study site with a four-question screener that was reviewed for responses. This tool has been in use at other organizations in the system to screen for spiritual distress and, accordingly, has face validity. The scoring for the tool is based on a Likert scale with possible scores ranging from 0 to 4 respectively. A patient receiving a score of five or higher was referred to the chaplain who then conducted a full spiritual assessment on the patient using the FICA tool (Larocca-Pitts, 2015). In addition, any patient that scored any question with a "quite a bit=3" or "extremely=4" was referred to the chaplain for a spiritual assessment.

The Faith, Importance, Community, and Address (FICA) assessments have been widely used for conducting a brief yet thorough spiritual assessment on patients believed to be in distress or struggling spiritually. The FICA assessment is otherwise known as faith and belief, importance, community, and address/action in care. The tool is useful in its ability to be integrated into a discussion with patients who are otherwise having difficulty communicating their spiritual struggles with their health care providers. For nursing, the tool is a great sequel into having a meaningful discussion with a patient

about spirituality (Williams, Voss, Vahle, & Capp, 2016). The FICA tool developed by Puchalski in 1996 is the only validated tool in todays' health care setting (Blaber, Jones, & Willis, 2015). One of the strengths of FICA is that it has been validated by another study as a means of assessing several dimensions of spirituality, identify nonreligious sources of meaning, highlight sources of religious support, and identify patients that want their spiritual needs integrated into their clinical care plan (Blaber et al., 2015). The FICA contains 11 questions that can be used by providers in any clinical setting but doesn't require a timely consultation (Lucchetti et al., 2013).

Reliability and validity have been established with the FICA tool, through a study using the assessment and analyzing its effectiveness when used in the clinical setting. One such study by Borneman et al. (2010) report internal consistency reliability is 0.77-0.89 using Cronbach's alpha for the four scales of the tool and 0.93 is the overall score for the FICA (Borneman et al., 2010). Quantitative and qualitative research was conducted using the FICA tool with breast cancer patients that were predominantly females and average age of 58. Content validity analysis of the FICA questions was used to identify themes to better understand respondents' answers to the 11 questions, and these responses were coded. The study's quantitative data showed that the FICA tool is able to help in the assessment of several spiritual dimensions of spirituality (Borneman et al., 2010). Blaber, Jones, and Willis (2015), report that of the four spiritual history taking assessment tools such as FAITH, SPIRIT, FICA, and HOPE, FICA is the only tool that has been validated by another research study thereby questioning the others credibility for use in a clinical setting.

Lucchetti, Bassi, and Granero Lucchetti (2013), stress the importance of the spiritual care history assessment about sharing the lessons learned from the patient. Learning about the patient's spiritual strengths and weaknesses, inner sources of acceptance and healing, and appropriately referring to chaplain or spiritual provider is vital. The authors report that the FICA tool is easy to remember, apply in clinical settings, and good to address spirituality in patients (Luchetti et al., 2013). An adequate and evidenced-based spiritual history should be patient centered and focused on the ability to evoke spiritual experiences and beliefs from the patient.

Theoretical and Ethical Framework

The Association of American Medical College (AAMC), and American College of Physicians (ACP) have all advocated for the incorporation of courses in spirituality and health within their medical students' curriculum of study. In the Code of Medical Ethics, physicians are bound by the oath to provide compassionate care and dignity to their patients (Puchalski et al., 2006; Puchalski, 2013). The AAMC and ACP believe that compassionate care encompasses attentiveness to the spiritual dimension of people's lives and treating the entire person as a whole. Treatment of patients' rights and need to respect spiritual and religious beliefs has become a common field of study within medical schools.

In nursing, theoretical framework of spirituality was seen with the development of nursing diagnosis for spiritual distress by the North American Nursing Diagnosis Association (NANDA) in 1978 (Puchalski et al., 2006). Nursing practice through the national associations and code of ethics vows the profession to provide competent and

compassionate care to all patients and families. As seen in the medical field, nursing also has largely focused on acute care of the physical needs of the patient and spiritual care is oftentimes overlooked.

There are two major fundamental theories within spiritual care that have guided this project: the patient-centered care model, and Dr. Marilyn Ray's bureaucratic theory of caring. Both model and theory provide a framework that centers spiritual care as an integral part of patient care that occurs. The patient centered care model theorizes that care should follow the shared-decision making framework and that the physician and patient are in partnership. In the patient centered care model, care should be discussed with the patient's input and agreement with the treatment plan. This model of care is also seen in other disciplines' curricula of study and utilized in nursing care today (Pullen et al., 2015).

The bureaucratic theory of caring states that nurses are tasked to complete patient care while building a trusting relationship with their patients. Nurses as a discipline will use economic caring techniques to ensure that despite financial burdens or strains the patient has their holistic needs met by the nurse. According to Dr. Marilyn Ray (Turkel, 2007), caring of the nurse is seen as an "opportunity cost" to the health care organization because the caring interaction with the patient outweighs the financial burden it entails. Future challenges show that a lack of trust within the organizations by nursing staff would negate the caring environment that the discipline proves to portray. When the discipline is equally grounded in economics and caring it proves to be a healthy relationship for nursing to provide holistic care to their patients (Turkel, 2007).

Relevance to Nursing Practice

The Joint Commission, states the importance of spiritual care by enacting a standard for provision of spiritual care for patients at their end of life, or palliative/hospice care (Burkhart & Hogan, 2008). Although nursing standard is to provide holistic care, which includes spiritual care, nursing education provides very little literature to help the discipline achieve this. Therefore, according to Burkhart and Hogan (2008), much research is needed to determine educational content of spiritual assessment and interventions that promote wellbeing and nursing theory could help guide that.

When faced with individuals with chronic debilitating illness, pain, spiritual distress, and death, nurses often strive to practice holistic care, which leads them and their patients to often consider the meaning and purpose of their respective lives (Rogers & Wattis, 2015). Patients often ask questions such as “why me?”, “How can I deal with this?”, and “What does this mean?” and these questions provide an opportunity for the nurse to explore the spiritual experiences and needs of that individual.

Nelson (2016) reports results from a 2010 Royal College of Nurses survey with United Kingdom nurses (n=4000) to study their attitudes toward spirituality. Of the nurses who participated in the survey, 93% believed that spiritual care should be addressed for a patient, however only 5% felt they meet this need all of the time (Nelson, 2016). Nelson (2016) described a recent story of a nurse in the United Kingdom who was suspended after offering to pray with a patient, and for giving a patient a prayer card (Nelson, 2016). Often, nurses are afraid of speaking to patients about spiritual or religious issues due to fear of being accused of imposing their own faith on their patient when the

latter is not necessarily true (Nelson, 2016). Nurses of a certain faith might also find it difficult to relate and talk to patients of a different faith due to this particular incident in the United Kingdom. There is often the lack of confidence in dealing with spiritual issues between nurses and their patients, therefore a sense of avoidance that comes into play (Nelson, 2016).

Some recommendations that emerged from Nelson's research (2016) relate to improving the ability for nurses to provide spiritual care for their patients is to increase formal nursing education to provide theoretical and clinical based opportunities for nurses during their basic education to assess and treat such patients. Also, Nelson (2016) observed that providing more time during a nurse's shift to sit with a patient and have a meaningful conversation that touches on the spiritual care needs of their patients is vital. Burkhart and Hogan (2008), further emphasized that education, practice, and awareness of patient cues, in the context of promoting patient-centered care will help nursing achieve integrating spirituality into their care.

This doctoral project addressed the gap in practice that occurs when nurses do not have the confidence or face some fears in providing spiritual care. The educational portion of the DNP project address this as nurses participating in the project were provided with a series of thought-provoking questions that will help facilitate the discussions they will need to have with their patients in order to build the rapport and respect that they truly care about their spiritual experience. In addition, patients will be more comfortable having spiritually based discussions with their nurse because they detect the sense of confidence portrayed by the nurse. The nurse, having more

understanding of how to provide spiritual care to their patient, will be challenged to help become an integrated discipline and refer their patients to pastoral services as required.

Local Background and Context

The local evidence on the relevance of this problem which justifies conducting this project is that there is no chaplain in the study site to help support patients undergoing a spiritual crises or struggle. Unlike active duty service men, dependents are not assigned to a chaplain or clergy to help improve their overall resiliency to deal with spiritual struggles. When there are no resources available to help solve the problem, then it is often ignored. It was imperative that this issue was addressed locally because it directly impacts the population being seen at the study site and other such clinics all over the country. There was a need to examine this topic because it directly influences patient satisfaction survey results and the overall care provided in health care organizations.

Role of the Doctor of Nursing Practice Student

My role in this doctoral project was that of a stakeholder and project manager. The context in which I began this project was through a relationship with one of the providers in the aforementioned study site where the project took place. We are both stakeholders in this project and value the success of the process. My relationship to the topic is that I have always inquired about spirituality since the beginning of my nursing practice. I have found it difficult to find enough time to connect with my patients on a spiritual level in order to identify any struggle they might be encountering. Most of the practice settings where I worked did not have the benefit of an embedded chaplain nor were screening tools or other educational devices available. My involvements were as a

primary DNP project manager to ensure that the project was completed in a timely manner.

My motivation for this project stems from an illness I had in recent years and how I have used my own spirituality and faith to overcome and not become debilitated by my experiences. I was in a dark, and saddened place in life, which caused me to become hospitalized for a period of time. That hospitalization was stressful, and a fearful period of time for me, but through some good support of family and close friends, in addition to utilizing faith-based activities and rituals such as prayer and bible study, I was able to get better and was discharged. I believe this experience opened my horizons to the fact that if I were to encounter such spiritual struggle in my life before and during hospitalization, then it must be an occurrence for other such individuals that would warrant similar actions. My perspective on life changed, and I realized that as I struggled and received minimal help from my medical team in the spiritual arena, other patients who were in similar or worse predicaments would also struggle, indeed. I foster no particular bias other than the fact that my background is in nursing and I am a highly spiritual person. I tend to make decisions and base most of my relationships on my faith and religious affiliation. I thereby struggle to be unbiased and open minded to other perspectives and varying opinions.

Summary

The gap in practice for identifying and treating patients who are undergoing spiritual struggle and distress that lack the necessary resources to cope and become resilient is evident in the previous paragraphs. Subsequent paragraphs will help the reader

identify sources of evidence and help clarify the relationship between the evidence and this project. Clarification of the purpose and how the doctoral project approach aligns with the practice question will be further explained.

Section 3: Collection and Analysis of Evidence

Introduction

The practice problem was that spiritual care is minimal or nonexistent in the primary care setting in most health care facilities, a problem that needs to be addressed globally. The practice-focused question this project answered was: Will embedding a chaplain in an outpatient clinic (new practice) instead of providing a pamphlet about chaplain services (standard practice) increase patient satisfaction among the study site population?

The local evidence on the relevance of this problem that justified conducting this project was that there was no chaplain on site to help support patients undergoing a spiritual crises or struggle. When there are no resources available to help solve the problem, the problem is often ignored. This is not appropriate or considered good evidence-based care. It was imperative that this issue was addressed locally because it directly impacted the population being seen at the study site and other such areas across the country. There is a need to examine this topic because it directly influences patient satisfaction survey results and the overall care provided in health care organizations.

At the main inpatient facility that is affiliated with the project site, which was the focus of this DNP project, there were two questions asked of the patients. The questions inquired about religious and spiritual background and needs while hospitalized; however, in the outpatient setting there was no such screening conducted. On the study sites' intake form, health related questions were asked of the patient, but there was no reference to the patients' spiritual needs. That became a missed opportunity that health care providers

could have used to screen and identify patients that needed spiritual counseling or support.

The purpose of this doctoral project was to answer the practice-focused question, and the particular approach to the project aligned with the practice issue. By conducting a screening assessment for spiritual distress and escorting the patient to the chaplain, the staff might be inclined and empowered to discuss spiritual issues with their patients. As a result of this project, staff were asked to literally escort the patient who scored high for spiritual distress directly to the chaplain. If the chaplain was not available at the time, the patient was asked to schedule an appointment for a later time during the chaplain's office hours. Providers would have the support of the embedded chaplain to complete a spiritual care consult.

Sources of Evidence

The published sources of evidence provided the theoretical and research underpinning for the project. The completed analysis results of the survey questions helped to identify if the findings answered the project question and demonstrated an increase in patients' satisfaction after interventions with the project chaplain. In addition, we tracked patients' level of satisfaction with the spiritual care they have obtained postintervention to better understand if the interventions were effective. Collection of the abovementioned information provided the appropriate way to address this practice issue because it helped prove that the issue needed to be resolved and that the approach was successful. The procedure for collecting screening data from study sites' patients was to incorporate a one-page four-question screener with their check-in forms. The screeners

and the forms were collected by the front desk staff and directly given to the patients' nurses who took them to a treatment room to assess vital signs and other conditions. The nurse reviewed the responses from the screener and determined if the patient needed to have a consult for spiritual care. This information was given to the provider who in turn notified the chaplain of a patient who would be walked to the chaplain's office for a warm-handoff. If the chaplain was unavailable, the patient scheduled an appointment with the chaplain during office hours and took the four-question screener with them to the meeting for the chaplain to review. If the first chaplain visit was within 2 weeks of the completion of the four-question screener, the chaplain had the patient complete a six question follow-up screener. If the visit scheduled with the chaplain was over 2 weeks of the initial four question screener, then the chaplain provided the patient with the entire ten-question spiritual assessment tool to help gauge where their spiritual needs were currently.

The screeners were used at the site to help increase the number of referrals to the chaplain for spiritual care needs by patients and providers. The screeners also helped providers open the doors of communication about spirituality with their patients by using the screener as an introduction to the conversation. Last, the screeners were used specifically by the chaplain to help identify areas for intervention with each individual patient based on their responses to the questions. The screener was used by the study site to collect data for analysis purposes at the aggregate level to determine themes in responses to each question. Each response was entered into an excel spreadsheet to help

biostatistician and writer to determine through analysis where each response fell in percentage of responses within each Likert scale category.

Published Outcomes and Research

A CINAHL search was performed using the keyword *spirituality,* and a filter was applied for only peer-reviewed journal articles that were published after 2000. The literature search yielded over 27,000 results that were relevant to the broad topic of spirituality. However, I needed to further explore the role that spirituality plays in the primary care setting. Therefore, I conducted a literature search with the keywords *spirituality in primary care,* which yielded 79 peer-reviewed journal articles published between 1997 and 2017. In reviewing the search results, articles with such topics such as "primary health care services—workplace spirituality and organizational performance" and "how family practice, nurse practitioners, and physician assistants incorporate spiritual care in practice" were further explored for definitions, terms, and relevance to topic issues. The main focus for articles to further explore were those that had spirituality and primary care in their titles. These searches were comprehensive and exhaustive to further identify articles that would be of relevance.

Archival and Operational Data

Measurement of patient satisfaction scores was done to leverage an already existing patient satisfaction survey of the study site and the care provided. We obtained access to the preintervention survey aggregate results, and then the results during and postintervention. We leveraged the same survey to obtain the aggregate data. This survey has been in existence for a number of years and is used throughout the facility to obtain

patient satisfaction scores for all encounters at the facility. It is called the joint outpatient experience survey (JOES; see Appendix C). These five survey items were extracted from the JOES survey that is presently in use at the project site. We did not modify or change this survey for the purpose of the QI project because it contains a lot of the data needed to adequately demonstrate improved patient satisfaction. JOES is used by all military health facilities to obtain information about patient satisfaction levels with clinics and outpatient areas. The JOES survey contains information that is used across the country and is managed by a tri-service working group. Beneficiaries of active duty service members complete the tool in order to rate their health care experience. Assessment of reliability is the first step of establishing the usefulness of a new measure such as this. The validity is then established not based on a particular study, but on validation from accumulated experiences using the survey tool.

Patient satisfaction data that was collected manually in the study site was used in this DNP project. There are several questions on spiritual care that are presently included in the outpatient patient satisfaction data. This operational data collection and analysis process has been in place at the site for over 3 years. My intention for this project was to provide an improvement in patients' perceptions of their outpatient experience through a screening process, an educational process with staff, and the work of an embedded chaplain in the study site. After two months of active screening, a comparison was made to previous 2-month survey responses prior to the use of the embedded chaplain on the items relating to spiritual health.

Evidence Generated for the Doctoral Project

The purpose of this QI project was to improve clinical processes by which the study site provides care to their patient population. The study site sees a trend in somatic complaints when spiritual needs are not met or are ignored by medical professionals who have been trained to assess, diagnose, and treat patients. There are several individuals who were paramount to the success of this project; their roles were crucial.

Participants. The study sites' leader of the embedded chaplain project was a doctoral prepared nurse scientist who had many years of experience with QI projects in this and in many other facilities nationwide. She was vested in this particular topic and project and therefore a supportive person at the site. The nurse administrator of the study site was a DNP prepared nurse who also served as a primary care provider at the site. She knew firsthand the potential implications of this project to the staff and patients. Data analysis was guided by the DNP project leader and facilitated by a biostatistician who was used for this project and who also served as an experienced consultant. The executive sponsor at the site for this project was a well-published licensed psychologist who taught at leading universities. The liaison between all individuals and the study site was a PhD prepared nurse who served as a senior social science analyst at affiliated organizations. These individuals served as members of the DNP project team.

Nurses and medical assistants at the primary care site participated in a training program to enhance their ability to detect spiritual care needs and to ask the trigger questions mentioned earlier. Medical assistants administered the screening tool to detect spiritual distress for interpretation by the nurse and providers. There were 15 members of

the study site team who participated in the training, which was approximately 45 minutes long and held on shift. All participants were required to attend the training program as part of their job requirement, and as the training was held during work hours, the participants were paid for their time to attend the training.

Procedures. The survey tools created for this QI project included the four question initial screener used on intake by the study site staff and a 10-question assessment survey that was conducted by the chaplain (Appendix A & B). This screener tool was derived from the National Comprehensive Cancer Network (2017) spiritual distress screen for patients, which has been validated and considered a reliable tool for use. The screening tool was used at the study site to assess and help identify patients who required spiritual care needs that were provided by the embedded chaplain. The screening tool was used for all patients during their intake to assist staff members and providers to appropriately identify patients that were undergoing any spiritual distress or have spiritual care needs. Data collection was made through the responses of the questions that were tabulated in an excel spreadsheet that contained no identifying information for patient privacy reasons.

The staff education tools that were developed for this QI project included brochures and fliers to educate staff in the study site about chaplaincy and pastoral care. These tools were developed to help staff understand the mission and goals of the project and help bridge the gap between other health disciplines and chaplains. There was also a one-page fact sheet (Appendix D) provided to staff members about how and when to use the screening tool. The fact sheet will also be distributed to the providers (nurse

practitioners and physicians in the study site) to help them understand when to initiate a pastoral care consult and when to warmly transfer the patient directly to the chaplain. The overall purpose of the screening program and surveys used was to help present results and the impact on patient satisfaction to an expert panel at the conclusion of the DNP project.

Protections. The Institutional Review Board (IRB) at Walden University has approved all activities and participants associated with this project with a permission number of 11-14-17-0530588. This project falls under the realm of medical treatment since all participants would have to screen positive with the tool and willingly participate in interventions with the chaplains to improve their health and well-being. There would be a safeguard of privacy as medical data is obtained and extracted from the medical record to ensure that HIPAA privacy regulations are not violated. Identifying data was removed before any data was provided to the DNP student. The Walden University IRB board before approval of this project would require this de-identification of patient data. The Walden IRBs ethics approval was needed and was sought to ensure that the project meets the guidelines and objectives of a QI initiative. In addition, an IRB approval was obtained from the facility to ensure appropriate actions were conducted for the QI project.

Analysis and Synthesis

The system used for tracking, recording, and organizing, the evidence was Excel. This system was used due to the nature of this project and the use of medical data for analysis. Patient satisfaction data from a period of time before and after the institution of the chaplain were collected and entered into an excel spreadsheet. These data were

entered by project site staff into the Excel spreadsheet and provided to me for secondary analysis. This created a de-identified dataset and ensured privacy of all participants. The data analyst and biostatistician in addition to the DNP student guiding the types of data used for analysis conducted all analysis of the data obtained. Data were available from the extracted information from either paper or electronic charts. The data entry personnel assured that no identifying information was included during data analysis.

Analysis of the data included running Cronbach's alpha internal consistency reliability statistics for all of the instruments used in the project: the four-item screener, the ten-item spiritual distress assessment instrument and the four items used from patient satisfaction questionnaire. In addition, t-tests were used to analyze the impact of the chaplain's role on patients' perceived satisfaction with their health care experience. Finally, a paired t test will be used with the patients who saw the chaplain. Descriptive statistics were used to determine the extent to which the screening tool surfaced the need for additional pastoral care consults and success in providing that care. Qualitative data includes the written comments from participants involved in the project.

Summary

Key points to highlight in this proposal were that QI and IRB approval were obtained before data entry, extraction, or analysis were initiated. The key individuals on the project team were all experienced in QI projects and well versed in conducting a project appropriately. Privacy of all participants in the QI process was maintained at all times, with any demographic information de-identified before data analysis. In section

four of this paper, evidence obtained and analytical strategies will be explained. The findings, limitations, and outcomes of the project would be further explored.

Section 4: Findings and Recommendations

Introduction

The local problem at my project site was lack of adequate and appropriate spiritual care provided to patients being seen by the providers in the setting. The gap in current practice was that spiritual care is often overlooked and ignored in most health care settings, particularly at my project location. My practice-focused question was: Will embedding a chaplain in an outpatient clinic (new practice) instead of providing a pamphlet about chaplain services (standard practice) increase patient satisfaction among the study site population? The overall purpose of the doctoral project was to improve the comprehensive care provided to patients, especially those experiencing spiritual distress.

Findings and Implications

The sources of evidence that were used for this project were actual patient satisfaction baseline survey results and postintervention satisfaction results. The evidence was obtained through identifying key results of the JOES analysis. The results of this survey were received from the facility officer who conducted the analysis for the facility. Postintervention results were obtained via a survey given to each participating patient by the project chaplain. The questions were provided in a Likert scale format in order to capture accurate scalable responses from participants. Analysis of satisfaction scores was performed using Chi square Fisher exact test to determine if there was a significant change between patients completing a satisfaction survey who saw the chaplain and those patients completing a satisfaction survey who did not see the chaplain.

The findings that resulted from the data analysis indicated that 306 patients completed the four-question screener during the project study period. From the whole sample of 306 patients, 70 screened positive for spiritual distress. Of these, there were 34 who completed interventions with the embedded chaplain. Of the 70 who screened positive for spiritual distress, there were 38 who refused the chaplain's services. Direct consult referrals from the behavioral health outpatient provider accounted for one of the patients seen by the chaplain; there were 34 patients who saw the chaplain during the project study period.

There were six respondents who had two sessions with the embedded chaplain and completed the 10-question assessment after a two-week interval. The total score was assessed for normality by the Shapiro-Wilks test, and the total score was found normally distributed. Therefore, the parametric test paired t test was used to examine whether the change between the postintervention total score and the preintervention total score was statistically significant. The paired *t* test result for the six participants who had spiritual distress measured before and after interventions with the chaplain showed a decrease in total spiritual distress score (-3.7), but due to the small sample size, it wasn't statistically significant ($p = 0.08$).

Data collected from patient satisfaction surveys were inadequate for any reliability for internal consistency as there were only 25 surveys collected in the 2 months prior to the start of the chaplaincy and nine surveys collected in the two-month period following the initiation of the chaplaincy program at the project site. However, Chi square analysis compared overall patient satisfaction scores on the four items of interest

for the five surveys captured after the chaplain started to the scores on the four surveys during the same time frame from patients who did not see the chaplain. There were four questions on the survey, measured on a five-point Likert scale (see Appendix C). The survey scores on each of the four items measuring satisfaction were totaled and scored as nominal data: highly satisfied or not. Those patients who saw the chaplain had higher scores than did those who did not (Fisher exact p =. 048).

Qualitative data from the patient satisfaction survey completed by interested participants were written on the anonymous survey provided to those who completed interventions with the chaplain. Some of the responses from patients were: “Keep up the good work”; “ make more opportunities for more people to be blessed by CH___! God given gift to heal the broken hearts of others”; “let more people know about this service, I have never heard about it.” These responses validated the importance of this initiative and the tremendous appreciation it received from its participants.

Some unanticipated limitations or outcomes were patient attrition and loss of a patient during the course of the project, which may have had some impact on staff and patients alike. It is also impossible to have total control over the overall patient experience due to factors such as interactions with other members of the health care team outside of the chaplain. These factors could impact the patient satisfaction responses.

The implications of the findings as they relate to individual patients are that a staff member can track individual patients’ responses to the screening and assessment questions. Assessing, identifying, and treating victims of spiritual distress are the objective of the project. The implications to individual patients are to provide the

information needed for overall holistic care of all patients. Social, physical, psychological, and spiritual care combined will enhance overall quality of life for those individuals who need it.

The potential implications to positive social change are substantial. The project has been well publicized to leadership, stakeholders, and other members of the health care community, and as a result it has gained popularity. In today's society, spirituality plays a large role in people's lives. When people are spiritually healthy, they experience greater and deeper connections with the world around them. Considerations are provided to those who actively seek a more spiritually-based existence by engaging with a chaplain who is well versed in the topic and its impact.

Recommendations

Proposed and recommended solutions to address this gap in practice are based on the results and lessons learned from the project. Ideally, holistic care includes spiritual considerations, assessments, and interventions of every patient in the health care setting. Revisions of clinic or hospital protocol to ensure providers are directed to identify, diagnose, and refer patients who screen positive from a screening targeted for spiritual concerns. Education of frontline providers is crucial to ensure that accurate, efficient information is provided to any individual that is deemed to be in spiritual distress. Interventions by the health care facility to encourage and provide appropriate resources for both patients and providers is to include a chaplain as a part of the multidisciplinary health care team. Practice guidelines should stress the inclusion of spiritually-based questions as part of the triage process for every patient. The standard of care should

include the spirituality-based considerations for every patient to be as highly important as any medical concern. Reasons are that psychosomatic complaints usually become the means to hide most spiritual distress issues. When policies are put into place to address the overarching need of the physical, psychological, social, and spiritual issues, holistic care will be the end result.

Contributions of the Doctoral Team

The process of working with the doctoral project team has been successful throughout the course of the project timeline. All team members had their individual and collective responsibilities and tasks to ensure continued and ongoing work. My role as the project manager dictated that I developed the project timeline, responsibilities, and tasks so that each member of the team had clear and reasonable expectations. I had to frequently communicate with each team member to address any issues or questions that arose at any point in time. The chaplain was instrumental in helping develop project handouts, brochures, and pamphlets. The chaplain was able to network with the other providers at the project site to ensure collaboration was established. In addition to the abovementioned responsibilities, the chaplain met with patients and providers who were referred during the period of the project. The chaplain entered raw patient response data into the excel spreadsheet for data collection.

The DNP project leader was a doctoral prepared nurse who provided leadership and clinical and technical oversight for the team. This individual was instrumental in communicating project needs to the facility administrators and key stakeholders. The biostatistician was responsible for providing technical assistance in relation to data

collection procedure, review, and analysis. The data analyst was responsible for providing needed baseline data by sharing extracted de-identified information to the project team and biostatistician.

The project team collectively contributed to the final recommendations from the project. The team had a consensus that the project should extend beyond the scope of a pilot in one clinic to other locations that would benefit from the same interventions. The dissemination of the project findings and lessons learned would be shared with key stakeholders and leadership who could potentially fund this type of project in other locations throughout the tri-state region and beyond.

Strengths and Limitations of the Project

Some unknown and likely strengths of the QI project are that the patients impacted by the chaplain and interventions are likely to experience better quality of life. Additional strengths are the ability to provide an additional resource for providers at the project site to refer patients. Also, patients and providers benefitted from the services, information, and interventions provided by the embedded chaplain. A few limitations noted for the DNP project are that the chaplain services were limited to only patients and providers in that particular location despite the need in other areas. A key limitation is that there was only one chaplain that could be embedded at the site, which could limit the number of patients seen at a time.

Our recommendations for future similar projects to address spiritual needs of patients are to first educate the staff and obtain buy-in from providers before implementation. A recommendation that would be disseminated will be to integrate the

electronic medical record and provide a detailed collaborative care plan that would be shared among providers and chaplain. Additionally, it will be beneficial to update policies and protocols to include the screening and referral process in the workflow for all providers.

Section 5: Dissemination Plan

My intent for this project is to improve spiritual care with an impact on the patients and staff; as it will be implemented by a health care administrator in the clinical setting. The lessons learned from the project and recommendations will be disseminated to the facility leadership in order for them to make any changes needed to improve the care provided to patients. A final project report drafted by myself and reviewed by project team members will be provided to senior leadership regardless of specialty. The dissemination plan for the project topic is an aim to publish a manuscript for the journal *Nursing Administration Quarterly*. My preceptor/mentor recommended this particular peer-reviewed journal as an appropriate option to disseminate the project findings due to the nature of the project and its impact on nursing leadership. The audiences who will be interested in this topic are chaplains, nursing health care administrators, and health care providers.

Analysis of Self

My role as a practitioner, scholar, and project manager was instrumental in ensuring the continuation of the project and enabled the success of project aims. Working as a scholar meant educating others and promoting the measures/aims that the project team sought to achieve. My project manager role enabled the beginning and end of the project in the time frame allotted. In order to stress the need for providing spiritual care to patients in spiritual distress, my role as a nursing practitioner came into play. My connection to this particular project experience reflects the interconnectedness between physical, psychological, and spiritual needs of each individual. This connection requires

the ability to engage stakeholders and all involved providers, which include nurses, physicians, and nurse practitioners in the project mission and goals. My long-term professional goal as it pertains to this topic of spiritual care is to help promote the need and be instrumental in establishing an avenue to provide the care needed.

Summary

The goal of the DNP QI project was to ensure that through the dissemination of these findings to the public and the health care organizations that need the information; spiritual care will expand and improve for those who need it. Appendix A shows an example of the integration of spiritual-based triage questions as a part of the initial patient intake upon arrival to any outpatient clinic areas.

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Appendix A: Spiritual Distress Screener

Please read each of following items and mark the box that best describes how you have generally felt over the last two weeks. Some items may not apply to you. If this is the case, please mark "N/A" to indicate that item is not applicable to you, and continue on to the next.

How much you have been bothered by each of the following over the last 2 weeks?						
	N/A	Not At All	A Little Bit	Moderately	Quite a Bit	Extremely
	N/A	0	1	2	3	4
1. Feeling troubled by doubts or questions about religion or spirituality						
2. Worry that my relationship with someone close to me will never improve (for example, a partner, a child, a friend)						
3. Feeling disconnected or misunderstood by my religious/spiritual community						
4. Thinking of a loss so much that I cannot do the things I normally do (for example, someone who died, loss of a job, loss of a relationship, and so on)						

Name:
_____(*Required)*
( ) Phone #:
_____(*Optional)*
( ) Email:
_____(*Optional)*

Would it be okay for the chaplain to contact you? ( ) Yes ( ) No

Preferred method of contact:
( ) Phone call ( ) Phone text ( ) Voicemail ( ) Email

Appendix B: Chaplain's Ten-Item Screener

How much you have been bothered by each of the following over the last 2 weeks?

N/A	Not At All	A Little Bit	Moderately	Quite a Bit	Extremely
	0	1	2	3	4

1. Feeling troubled by doubts or questions about religion or spirituality
2. Worry that I could never forgive myself for things I've done
3. Avoiding memories and reminders of someone who has died
4. Worry that my relationship with someone close to me will never improve (for example, a partner, a child, a friend)
5. Feeling disconnected or misunderstood by my religious/spiritual community
6. Thinking of a loss so much that I cannot do the things I normally do (for example, someone who died, loss of a job, loss of a relationship, and so on)
7. Feeling angry at God or a Higher Power
8. Worry that my actions were morally or spiritually wrong
9. Feeling as though God or a Higher Power has abandoned me
10. Concerns about whether there is any ultimate purpose to my life or existence

Appendix C: Patient Satisfaction Items Used in the Doctor of Nursing Practice Project

Family Health Clinic

Patient Satisfaction Survey

Please answer the questions below by using the scale and explain any " Very Dissatisfied/Dissatisfied" in the comment space below.

1. Rate the service received today:

Very Dissatisfied	*Dissatisfied*	*Neutral*	*Satisfied*	*Very Satisfied*
1	*2*	*3*	*4*	*5*

2. How would you rate the courtesy and helpfulness of the staff during this visit:

Very Dissatisfied	*Dissatisfied*	*Neutral*	*Satisfied*	*Very Satisfied*
1	2	3	4	5

3. Rate how we met your expectations with the services provided today:

Very Dissatisfied	*Dissatisfied*	*Neutral*	*Satisfied*	*Very Satisfied*
1	2	3	4	5

4. How would you rate us on the fact that your privacy and confidentiality at this visit was adequately maintained:

Very Dissatisfied	*Dissatisfied*	*Neutral*	*Satisfied*	*Very Satisfied*
1	2	3	4	5

5. What could we do better? _____

_____

_____

_____

Appendix D: Family Health Center Staff Instructions

1. The Spiritual Distress Screening Tool will be scored using the following values: Not at all or Not applicable= 0; a little bit= 1; Moderately= 2; Quite a bit= 3; Extremely= 4
2. A patient receiving a score of five or more on the screening tool is referred to a chaplain who will conduct a spiritual assessment. Additionally, any patient who responds "quite a bit" or "Extremely" to any item on the screening tool will also be referred to a chaplain for spiritual assessment.
3. The IBHC provider will discuss the results with the patient: ex *"Based on the way you've answered these questions, it looks like you might be having a hard time with some things that a Chaplain might be able to help with. Would you be okay with being contacted by a Chaplain?"*
4. The provider (IBHC) orders a spiritual assessment by contacting the chaplain over encrypted email, providing the patient's phone number and email address using the standard email title: "Internal Medicine Chaplain Referral"
5. The chaplain contacts the patient and schedules a spiritual assessment appointment.
6. Once the spiritual assessment is complete, the chaplain provides assessment results to the referring provider (IBHC).
7. The chaplain and provider (IBHC) then work as a team in determining next steps for the patient.